HEALTH CARE FINANCING ADMINISTRATION
SPECIAL TERMS AND CONDITIONS (STC)

NUMBER: 11-W00063/3

TITLE: Delaware Diamond State Health Plan (DSHP)

AWARDEE: State of Delaware Department of Health & Social Services

NOTE: All special terms and conditions prefaced with an asterisk (*) contain requirements that must be approved by the Health Care Financing Administration (HCFA) prior to marketing, enrollment, or implementation. No Financial Federal Participation (FFP) will be provided for marketing, enrollment or implementation until HCFA has approved these requirements. Unless otherwise specified where the State is required to obtain HCFA approval of a submission, HCFA will make every effort to respond to the submission in writing within 30 days of receipt of the submission.

1. a. All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the award letter of which these terms and conditions are part, shall apply to the DSHP. To the extent the enforcement of such laws, regulations, and policy statements would have affected State spending in the absence of the DSHP demonstration in ways not explicitly anticipated in this agreement, HCFA shall incorporate such effects into a modified budget limit for DSHP. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement, HCFA will have two years after the determination of the budget neutrality base for DSHP to notify the State that it intends to take action. The growth rates for the budget neutrality baseline, as described in Attachment **A,** are not subject to change under this special term and condition. If any portion of the law, regulation, or policy statement cannot be linked specifically with program components that are or are not affected by the DSHP demonstration (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the State's budget limit shall be proportional to the size of the DSHP demonstration in comparison to its entire Medicaid program (as measured in aggregate Medical Assistance Payments).

b. The State shall, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the approval date of this waiver. To the extent that a change in Federal law, that impacts statewide section 1115 demonstrations such as DSHP, would affect State Medicaid spending in the absence of the waiver, HCFA shall incorporate such changes in law into a modified budget limit for DSHP. The modified budget limit would be effective upon implementation of the change Federal law, as specified in law. If mandated changes in the Federal law require

State legislation, the change shall take effect on the day such State legislation becomes effective, or in the absence of such legislation, on the last day such legislation was required. If any portion of the new law cannot be linked specifically with program components that are or are not affected by the DSHP demonstration (e.g., laws affecting sources of Medicaid funding), the effect of the new law on the State's budget limit shall be proportional to the size of the DSHP demonstration in comparison to its entire Medicaid program (as measured in aggregate Medical Assistance Payments).

c. The State may submit to HCFA an amendment to the DSHP to request exemption from changes in law occurring after the approval date of this waiver. The cost to the Federal government of such an amendment must be offset to ensure that total projected expenditures under the modified DSHP does not exceed projected expenditures in the absence of DSHP (assuming full compliance with the change in law).

d. **Any** significant modifications by the State to the DSHP program must be submitted in writing and are subject to approval by HCFA.

2. Within 30 days of award, the State shall submit a pre-implementation workplan for review by HCFA. The workplan will specify timeframes for major milestones and related subtasks for DSHP demonstration.

***3.** The State shall prepare one protocol document that represents the policy and operating provisions applicable to this demonstration which have been agreed to by the State and HCFA. The protocol must be submitted to HCFA no later than 90 days prior to implementation. HCFA will respond within **45** days of receipt of the protocol. During the demonstration, subsequent changes to the protocol should be submitted on an ongoing basis no later than 90 days prior to the date of implementation for approval by HCFA. A number of Special Terms and Conditions include requirements which should be included in the protocol. Attachment C in the original terms and conditions presented an outline of areas that should be included in the protocol.

4. a. The State shall submit a phase-out plan of the demonstration to HCFA 6 months prior to initiating normal phase-out activities and, if desired by the State, an extension plan on a timely basis to prevent disenrollment of DSHP members if the waiver is extended by HCFA. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to HCFA review and approval.

b. During the last 6 months of the demonstration, eligibility determination of individuals who would not be eligible for Medicaid under the current State plan will not be permitted unless the waiver is extended by HCFA.

Encounter Data

* **5.** a. The State shall define a minimum data set (which at least includes inpatient and physician services) and require all providers to submit these data. The recommended minimum data set was attached to the original special terms and conditions. The State must perform periodic reviews, including validation studies, in order to ensure compliance, and shall have provisions in its contract with the managed care organizations to provide the data and be authorized to impose financial penalties if accurate data are not submitted in a timely fashion. As part of the protocol, the State shall submit the proposed minimum data set and a workplan showing how collection of plan encounter data will be implemented and monitored, what resources will be assigned to this effort, and how the State will use the encounter data to monitor implementation of the project and feed findings directly into program change on a timely basis. If the State fails to provide reasonably accurate and complete encounter data for any managed care plan, it will be responsible for providing to the designated HCFA evaluator data abstracted from medical records comparable to the data which would be available from encounter reporting requirements.

b. The State, in collaboration with managed care organizations and other appropriate parties, will develop a detailed plan, as part of the protocol, for using encounter data to pursue health care quality improvement. At a minimum, the plan shall include: how the baseline for comparison will be developed; what indicators of quality will be used to determine if the desired outcomes are achieved; where the data will be stored; how data will be validated and how monitoring will occur; and what penalties will be incurred if information is not provided.

c. At a minimum, the State's plan for using encounter data to pursue health care quality improvement must focus on the following priority areas:

- childhood immunizations;
- prenatal care and birth outcomes;
- pediatric asthma; and
- two additional clinical conditions to be determined based upon the population(s) served.

d. The State shall conduct annual validity studies to determine the completeness and accuracy of the encounter data collected. In the protocol the State shall submit a plan for HCFA approval on how it will validate the completeness and accuracy of the encounter data.

Eligibility

*6. The State will continue to maintain a Medicaid Eligibility Quality Control (MEQC) program. The State may extend its current MEQC program to the demonstration population or submit an alternative method for carrying out its MEQC responsibilities. If the State wishes to use an alternative method, it must submit for review and approval a detailed description of the review and sampling methods within 120 days of the award. If the State does not submit an alternative method within this time-frame, the State will maintain its current MEQC program for its demonstration and non-demonstration populations.

Enrollment

7. The State shall include in the protocol a detailed description of the Health Benefits Manager (HBM). This description needs to include the qualification and training procedures for the HBM. Information on how plans will be presented in an unbiased manner and procedures for auto-assignment should be detailed. Furthermore, a plan for monitoring the HBMs performance should be included in the protocol.

Federal Financial Participation/Cost Control/Fiscal Administration

8. The State shall submit to HCFA for review and approval all capitation rates, and the fee-for-service upper payment limits from which they are derived, for the managed care organizations throughout the demonstration.

9. a. The State shall provide quarterly expenditure reports using the form HCFA 64 to separately report expenditures for those receiving services under the Medicaid program and those participating in DSHP under section 1115 authority. HCFA will provide FFP only for allowable DSHP expenditures that do not exceed the pre-defined limits as specified in Attachment A.

b. In order to track expenditures under this demonstration, Delaware must submit a complete form HCFA 64 through the MBES that clearly differentiates between expenditures made under the authority in HCFA's approval of the DSHP demonstration and expenditures which were made under ordinary Medicaid rules not affected by the waiver, on a quarterly basis according to standard Medicaid reporting requirements. In addition, quarterly supplemental schedules, that reconcile to the reported HCFA-64 DSHP amounts, must be concurrently submitted that detail DSHP services. The cash payments (current and prior period) reported for DSHP on the HCFA-64 must be by service date year and must separately identify all capitated and non-capitated payments for each State agency. The procedures related to this reporting process must be approved by HCFA as part of the protocol referenced in STC #3. Administrative costs for the waiver need not be separated from non-waiver administrative costs.

c. In addition to the form HCFA 64, the State shall provide to HCFA on an annual basis (related to the period for which the expenditure limit is established) the actual caseloads on a member month basis for each traditional Medicaid eligibility group (i.e., AFDC and AFDC related-adult, AFDC and AFDC related-children, SSI cash-adult, SSI cash-children) and DSHP eligibles. Adults are individuals over 21 years and children are under 21 years. This information should be provided to HCFA 90 days after the end of the year.

d. For a period of two years after the termination of the waiver, the State must continue to separately identify net expenditures related to dates of service during the operation of the 1115 waiver on the form HCFA 64 in order to properly account for these expenditures in determining budget neutrality.

10. The standard Medicaid funding process will be used during the demonstration. DSHP must estimate matchable Delaware Medicaid expenditures on the quarterly form HCFA-37. HCFA will make Federal funds available each quarter based upon the State's estimates, as approved by HCFA. Within 30 days after the end of each quarter, the State must submit the form HCFA-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. HCFA will reconcile expenditures reported on the Form HCFA-64 with Federal funding previously made available to the State for that quarter, and include the reconciling adjustment in a separate grant award to the State.

11. HCFA will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in Attachment A:

    a. Administrative costs associated with the direct administration of DSHP.
    b. Net expenditures and prior period adjustments of the Medicaid program which are paid in accordance with the approved State plan.
    c. Expenditures for current and new eligibles under DSHP.

Family Planning

12. In the protocol referenced in STC #3, the State shall include a complete description of the expanded family planning benefit including, the scope of services, the eligibility process and requirements for the 2 year benefit, and a discussion of the infrastructure available to provide the services.

***13.** In the protocol, the State shall submit a written plan that describes how family planning services will be made available to DSHP enrollees, if managed care organizations choose not to contract with title X programs. The plan must delineate how the confidentiality of enrollees (particularly adolescents) who receive family planning services through such health plans will be maintained.

Federally Qualified Health Centers (FQHCs)

*14. a. The State shall require managed care health plans to contract with FQHCs. However, if the State can demonstrate to HCFA that the plans have adequate capacity and will provide an appropriate range of services for vulnerable populations without contracting with an FQHC in its service area, the managed care health plan can be relieved of this requirement.

b. For any managed care health plan that requests relief from the requirement, the State shall submit to HCFA a report with the following information at least 60 days prior to submission of the final managed care contract for HCFA approval:

1. The FQHCs in the managed care health plan's service area, and a description of the demonstration populations served and the services provided by the FQHCs prior to the demonstration.

2. ***An*** analysis that the managed care health plan has sufficient provider capacity to serve the demonstration populations currently receiving services at the FQHC. The analysis should include, but not be limited to, a listing of providers signed with the managed care organization, capacity of each provider to take on additional Medicaid patients, geographic location of providers and description of accessibility for Medicaid patients to these providers. The managed care health plan must inform the State if any of this information or data changes over the course of the demonstration.

3. ***An*** analysis that the managed care health plan will provide a comparable level of Medicaid services as the FQHC (as covered in the approved State plan), including covered outreach, social support services, and the availability of culturally sensitive services, such as translators and training for medical and administrative staff The analysis should describe the proximity of providers, and range of services as it relates to FQHC patients.

c. The managed care organization will pay the FQHC(s) on either a capitated (risk) basis (with appropriate adjustments for risk factors) or on a cost-related basis as referenced in 42 CFR 405.2401 to the end of 405. A description of the payment methodology shall be provided by the State. If during the demonstration, the managed care organization changes its payment methodology to an FQHC, the changes must be submitted by the State to HCFA for review and approval.

Providers and Delivery Systems

15. The State shall use a Request for Proposal (RFP) process to select contracting managed care plans. The process will be open to all plans that meet the DSHP participation standards including minority owned plans. Before issuing the solicitation for managed care plans for services under DSHP, the State shall submit the RFP for review and allow 30 days for HCFA to provide comments.

*16. Before issuing the solicitation for the Health Benefits Manager contract, the State shall submit the RFP for approval.

*17. The State shall describe in the protocol the integration between the DSHP managed care organizations and the Nemours program.

*18. a. The State indicates that five entities in Delaware will be responsible for delivering health care services for Medicaid: DSHP managed care contractors; Nemours clinics, school-based health clinics, DE State agencies; and fee-for-service providers (e.g., dentists, mental health service providers, FQHCs, and RHCs and other providers). The State must include in the protocol their plans to assure coordination of benefits between the managed care organization's primary care providers and the entities mentioned above and should include plans for monitoring utilization of services and ensuring against duplication of services.

19. The State shall contract with at least two managed care organizations per County. The contracted health plans should demonstrate the ability to provide services to all Medicaid recipients in a given County and deliver benefits from a prescribed benefit package in an expanding-enrollment environment. Criteria should be delineated for individuals to disenroll for good cause.

*20. a. Model contracts between the State and managed care organizations must be approved by HCFA prior to its use. The State shall provide information for each managed care organization on its overall capacity and capacity by provider type prior to approval of the contract. The State shall provide HCFA with 30 days to review and approve the model contracts between the State and managed care organizations prior to the start date of the delivery of services. No FFP will be available for contracts using a contract form which has not been approved by HCFA in advance of the effective dates of the contracts. Furthermore, prior to marketing and enrollment, the State shall demonstrate to HCFA that sufficient access and capacity are available to potential enrollees under DSHP. At a minimum, the State shall meet the access requirements detailed in Attachment B of the original terms and conditions. Marketing and/or enrollment shall not be initiated prior to receiving written approval by HCFA.

b. Significant changes to any provider network which affect access and quality of care must be approved by HCFA.

c. In the protocol, the State shall submit to HCFA its contingency plans for assuring continued access to care for enrollees in the case of a managed care organizations contract termination and/or insolvency.

d. HCFA reserves the right to review and approve individual subcontracts with managed care organizations in accordance with the same requirements as those imposed by these Special Terms and Conditions on managed care organization. Copies of subcontracts or individual provider agreements with managed care organizations shall be provided to HCFA upon request.

e. In the protocol, the State shall describe its mechanism for reviewing all marketing materials used to promote enrollment in the managed care plans. The State shall not begin disseminating such materials until the marketing part of the protocol is approved by HCFA.

*21. The State must meet the usual Medicaid disclosure requirements at 42 CFR 455, Subpart B, for contracting with managed care organizations before the start date of the demonstration; these requirements include disclosure of ownership and completion of the standard HCFA disclosure form.

Quality Assurance

*22. In the protocol, the State shall provide its overall quality assurance monitoring plan for the managed care organizations. The State shall develop internal and external audits to monitor the performance of the plans under DSHP. At a minimum, the State shall monitor the financial performance and quality assurance activities of each plan. In the protocol, the State shall provide detailed criteria for monitoring the financial performance and quality assurance of each plan. The plan must include contingencies if provider networks are terminated or become insolvent. The State shall submit to the Center for Medicaid and State Operations (ORD) and the HCFA Regional Office copies of all financial audits of participating managed care organizations and quality assessment reviews of these plans, including findings from all licensure inspections.

23. a. Within 12 months of implementation, the State shall conduct a survey of each managed care organization. The survey, which shall be described in the protocol, will measure satisfaction and include measures of out-of-plan use, to include use of emergency rooms; average waiting time for appointments, including physician office visits; average time and distance to reach providers; access to special providers; and the number and causes of disenrollment; and coordination with other health programs. Results of the survey must be provided to HCFA by the fifteenth month of project implementation. Thereafter, the State shall conduct beneficiary surveys during each year of the demonstration as part of its quality improvement and performance monitoring process. By the second year the survey will be statistically valid.

b. The State shall establish a quality improvement process for bringing managed care organizations which score below 70 percent in overall beneficiary satisfaction, up to an acceptable level.

24. Delaware shall collect and report quarterly data on grievances received by each managed care organization and describe the resolution of each grievance.

25. Managed care organizations will satisfy access and solvency standards established by HCFA pursuant to 1903(m)(1)(A)(i)(ii), and shall meet requirements in 1902(w).

Administration/Reporting/Other

26. By April 1 of each year, the State shall submit Form HCFA-416, EPSDT program reports for the previous Federal fiscal year. These reports will follow the format specified in section 2700.4 of the State Medicaid Manual, with data for each line item arrayed by age group and basis of eligibility. Copies should be submitted simultaneously to HCFA's Regional Office and to the HCFA Central Office address contained in section 2700.4 of the State Medicaid Manual. All data reported must be supported by documentation consistent with the general requirements of these terms and conditions.

27. All contracts and subcontracts for services related to DSHP must provide that the State agency and the U.S. Department of Health and Human Services may: (1) evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed and (2) inspect and audit any financial records of such contractor/subcontractors.

28. a. Through the first 6 months after implementation, the State shall submit monthly progress reports to the HCFA project officer, which are due 20 days after the end of each calendar month. Subsequently, the State shall submit quarterly progress reports, which are due 60 days after the end of each quarter.

b. The reports should include a discussion of events occurring during the quarter that affect health care delivery, enrollment and outreach, quality of care (including statistics on grievances), utilization, access, managed care organization's financial performance, the benefit package, and other operational issues. The reports should include a separate discussion of State efforts related to the collection and verification of encounter data. The reports should also include proposals for addressing any problems identified in each report.

29. The State shall submit a draft annual report, documenting accomplishments, project status, quantitative and case study findings, and policy and administrative difficulties no later than 120 days after to the end of its operational year. Within 30 days of receipt of comments from ORD, a final annual report will be submitted.

30. Any additions or modifications that the State wants to make to the DSHP demonstration must be submitted as an amendment to the protocol for HCFA review and approval. If the State plans to introduce additional benefits in the DSHP demonstration, such as dental care, the State must request HCFA's approval. If the State plans to modify reimbursement for services, (e.g. future possibility of implementing a managed mental health care system by paying the Department of Services for Children, Youth and Their Families (DSCYF)), the State must request HCFA's approval.

*31. The State must implement procedures so that hospitals will be able to distinguish between individuals eligible for Medicaid under the demonstration through the expanded eligibility and all other Medicaid eligibles. These procedures must be in place and operational on the implementation date of the waiver so that hospitals can calculate Medicaid days

throughout the life of the waiver. Correct accounting for Medicaid days is required for calculating a hospitals Medicare disproportionate share hospital (DSH) payments. The proposed procedure must be submitted to HCFA in the protocol.

*32. Prior to enrollment of beneficiaries, the State shall submit evidence to HCFA that a management information system is in place which meets the minimum standards of performance or the functional equivalent required of the State's current management information system.

33. At the end of the demonstration, a draft final report should be submitted to the HCFA project officer for comments. HCFA's comments should be taken into consideration by the awardee for incorporation into the final report. The awardee should use the HCFA, Office of Research and Demonstrations' Author's Guidelines: Grants and Contracts Final Reports (copy available upon request) in the preparation of the final report. The final report is due no later than 90 days after the termination of the project.

34. HCFA may suspend or terminate any project in whole or in part at any time before the date of expiration, whenever it determines that the awardee has materially failed to comply with the terms of the project. HCFA will promptly notify the awardee in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights to challenge HCFA's finding that the State materially failed to comply. HCFA reserves the right to withdraw waivers at any time if it determines that continuing the waivers would no longer be in the public interest. If a waiver is withdrawn, HCFA will be liable for only normal close-out costs.

35. The State shall develop and submit detailed plans to protect the confidentiality of all project-related information that identifies individuals. The plan must specify that such information is confidential, that it may not be disclosed directly or indirectly except for purposes directly connected with the conduct of the project and the administration of the Medicaid program, including, evaluations conducted by the independent evaluator selected by the State and/or HCFA, or evaluations performed or arranged by State agencies. Informed written consent of the individual must be obtained for any other disclosure.

36. HCFA will contract with an independent contractor to evaluate the demonstration. The State agrees to cooperate with the evaluator by responding in a timely manner to requests for interviews, access to records, and sharing of data. The State has the right to review reports prepared by the evaluator. Data sharing is specified in other terms and conditions.

37. Any letters, documents or other material sent to the project officer should also be sent to the Regional Office.

Monitoring Budget Neutrality for the Diamond State Health Plan Demonstration

The following describes the method by which budget neutrality will be assured under the Diamond State Health Plan (DSHP) demonstration. Delaware will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the waiver period. This limit will be determined using a per capita cost method. In this way, Delaware will be at risk for the per capita cost (as determined by the method described below) for current eligibles, but not at risk for the number of current eligibles. By providing Federal Financial Participation for all current eligibles, Delaware will not be at risk for changing economic conditions. However, by placing Delaware at risk for the per capita costs of current eligibles, HCFA assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

For the purpose of calculating the overall expenditure limit for the demonstration, separate budget estimates will be calculated for each year, on a Federal fiscal year (FFY) basis. These annual estimates will then be added together to obtain an expenditure estimate for the entire waiver period. The Federal share of this estimate will represent the maximum amount of Federal Financial Participation (FFP) that the State may receive during the 8-year waiver period (January 1, 1996 through December 31,2003) for the types of Medicaid expenditures described below. For each FFY, the Federal share will be calculated using the FMAP rate for that year.

Each yearly budget estimate will be the sum of twelve separate cost projections. For this purpose, current Medicaid enrollees participating in the demonstration are divided into four enrollee groups, and Medicaid services provided to them under the demonstration are divided into three expenditure categories, resulting in twelve enrollee groups/expenditure categories (EGEC). The four enrollee groups are (A) AFDC and AFDC related children (age 20 and below), (B) AFDC and AFDC related adults (age 21 and above), (C) SSI cash recipient children (age 20 and below), and (D) SSI cash recipient adults (age 21 and above). The three expenditure categories are (i) all services that are included in the waiver package, excluding mental health and pharmacy services, (ii) mental health services, and (iii) pharmacy services. The yearly cost projection for each EGEC will be the product of the projected per capita cost for that EGEC, times the actual number of enrollee/months in that group, as reported to HCFA by the State under STC #9(c).

Projected per capita cost The State shall submit to HCFA a base year per capita cost for each EGEC, subject to the approval of the Project Officer, These should reflect all expenditures related to services performed during FFY 1994 (i.e., expenditures should be totaled on a date of service basis) in the enrollee groups and service categories listed above. Per capita costs for FFY 1995 and beyond will be derived by inflating the FFY 1994 per capita costs, using the rates of increase shown in the attached table.

Sample calculation Suppose the base year per capita cost for EGEC B.ii (mental health services for AFDC and AFDC related adults is $20.53. Using the rates of increase in the attached table, the projected per capita cost for this category in FFY 1996 is $35.77. Suppose further that during FFY 1996, the State reports 166,507 enrollee/months. The resulting budget estimate for EGEC B.ii in FFY 1996 is $35.77 X 166,507 = $5,956,000. The same calculation is repeated for the other eleven EGECs, and the twelve estimates are added together to obtain a budget estimate for the year.

The limit calculated above will apply to actual expenditures, as reported by the State under STC #9(a). If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to HCFA. No new limit is placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the 8-year period, the budget neutrality test will be based on the time period through the termination date.

PER CAPITA GROWTH RATES FOR THE DIAMOND STATE HEALTH PLAN

Key:
(A) AFDC and AFDC related children
(B) AFDC and AFDC related adults
(C) SSI cash recipient children
(D) SSI cash recipient adults

(i) all services except mental health and pharmacy

	(A)	(B)	(C)	(D)
1995	8.80%	8.80%	8.10%	15.00%
1996	6.79%	6.17%	6.85%	6.85%
1997	6.79%	6.17%	6.85%	6.85%
1998	6.79%	6.17%	6.85%	6.85%
1999	6.79%	6.17%	6.85%	6.85%
2000	6.79%	6.17%	6.85%	6.85%
2001	6.79%	6.17%	6.85%	6.85%
2002	6.79%	6.17%	6.85%	6.85%
2003	6.79%	6.17%	6.85%	6.85%

(ii) mental health

	(A)	(B)	(C)	(D)
1995	29.80%	29.80%	29.80%	29.80%
1996	29.80%	29.80%	29.80%	29.80%
1997	6.79%	6.17%	6.85%	6.85%
1998	6.79%	6.17%	6.85%	6.85%
1999	6.79%	6.17%	6.85%	6.85%
2000	6.79%	6.17%	6.85%	6.85%
2001	6.79%	6.17%	6.85%	6.85%
2002	6.79%	6.17%	6.85%	6.85%
2003	6.79%	6.17%	6.85%	6.85%

(iii) pharmacy

	(A)	(B)	(C)	(D)
1995	25.30%	32.00%	21.00%	27.40%
1996	25.30%	32.00%	21.00%	27.40%
1997	6.79%	6.17%	6.85%	6.85%
1998	6.79%	6.17%	6.85%	6.85%
1999	6.79%	6.17%	6.85%	6.85%
2000	6.79%	6.17%	6.85%	6.85%
2001	6.79%	6.17%	6.85%	6.85%
2002	6.79%	6.17%	6.85%	6.85%
2003	6.79%	6.17%	6.85%	6.85%